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ABSTRACT

This research examined specific communication patterns in 20 schizophrenic and other family triads, through analysis of transcripts of 15-minute interactions within a systems epistemology. Families with a son or daughter diagnosed as having schizophrenia were found to emphasize two communication patterns: communication that is nebulous, confusing, and egocentric, and communication that is disconfirming of individuality. Families of offspring with other psychiatric diagnoses, usually affective disorders, were found to emphasize nonnegotiable relationship-defining communication. (24 references) (Author/JDD)

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Family Communication Patterns
Consistent with Psychiatric Diagnosis of Identified Patient

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Running Head: Family Communication

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Abstract

Transcripts of 15-minute interactions in schizophrenic and other family triads were examined for communication-pattern consistency. Families with a son or daughter diagnosed as schizophrenic were found to emphasize 2 communication patterns: communication that is nebulous, confusing, and egocentric, and communication that is disconfirming of individuality. Families of offspring with other psychiatric diagnoses, usually affective disorders, were found to emphasize nonnegotiable relationship-defining communication.

This research was grounded in contemporary theory and research on schizophrenia, family interaction, and communication; was conducted with careful methodological controls; and was designed and executed within a systems epistemology.

Introduction

In contemporary family therapy, researchers increasingly attend to differences in epistemology in the examination of psychopathology, family interaction, and other communication (e.g., Bateson, 1979; Blakar, 1980). Greater awareness of the epistemology of system and pattern is leading to the utilization of research designs and analyses that take into account pattern and process in human interaction. Research now examines patterns in addition to isolated datum counts, and/or system as well as individual differences (e.g., Cohen & Christensen, 1980; Raush, Barry, Hertel, & Swain, 1974; Reiss & Costell, 1977; Sherblom & Bayer, 1985; Straker & Jacobson, 1979). Improved methodological controls and increasing sophistication of research design have also enhanced the validity and reliability of family-interaction research (Hodgson & Lewis, 1979; Jacob, 1975).

The present research examined specific communication patterns within a systems theoretical framework. Although great complexity and idiosyncrasy of meaning exist within individual interpersonal systems, similarities in process interaction are distinguishable in particular communication patterns (e.g., uninterpretability, pseudoagreement, attack, counterattack, withdrawal, self-denunciation, etc.).

Previous family-interaction theory and research have

suggested communication patterns which distinguish families with schizophrenic members from other families. The research of Wynne and Singer, Lidz, Blakar, and their colleagues found that the communication of parents of schizophrenics suggests mild thought disorder--an interactional thought disorder involving egocentric, idiosyncratic, confusing verbal and nonverbal communication which maintains the appearance of shared reality among family members (Blakar, 1980; Lidz, Cornelison, Terry, & Fleck, 1958; Singer, 1967; Wynne & Singer, 1963; Wynne, Singer, Bartko, & Toohey, 1977). This kind of communication, Egocentric communication is one pattern examined in the present research.

Other communication-deviance research found that communication in families with schizophrenic members was controlling as well as confusing, but most often indirectly rather than explicitly (e.g., Lennard, Beaulieu, & Embrey, 1965). Communication in families with psychiatric diagnoses other than schizophrenia was characterized by relationship rules and limits (e.g., McPherson, 1970; McPherson, Goldstein, & Rodnick, 1973). Communication which openly attempts regulation of family relationships, Relationship-Defining communication, is the second pattern examined in the present research.

Blakar (1980), Laing, (1965, 1971), Bateson (1972, 1979), and their colleagues (e.g., Bateson, Jackson, Haley, & Weakland, 1956; Mossige, Pettersen, & Blakar, 1980; Watzlawick, Beavin, & Jackson, 1967) distinguish the third pattern of communication

investigated in this research. Disconfirming communication rejects not only the validity of the speaker's statement and the implied definition of the relationship between speaker and listener, but also rejects the reality of the speaker. It is a disqualification of the person, not just of the assertion, and it is usually covert, implicit, indirect.

The present research was designed to look specifically for these three communication patterns, more fully described by Bayer (1982), in 20 families. Some characteristics of each pattern, with examples from the research transcripts, follow:

Egocentricity: Fragmentation ("Now when you started--your sisters--telling stories or somethin'--they'd scratch your back?"); unwillingness to let meaning stand ("...you went to AA. But you wouldn't go to AA, 'cause you didn't wanna listen. I think you did go to AA."); statements that can be interpreted in more than one way (responding to, "I don't like being complimented" with, "Well, I don't see anything wrong in that."); barely intelligible remarks ("It might directly say, 'I like your taste,' but you would say, 'I like your taste because I like what you taste--you bought--and I take it.'"); shifts in tense, pronoun, antecedent, etc. ("When you got in a real problem, you'd come to us and ask you to help them out of it."); unusual phrasing ("Well, awareness leads to many roads, if it's applied."); expecting (or giving) agreement when the meaning is not clear ("I mean, you must realize that you should, you

start..." finished with a circular motion of the hand); and nonsequitur reasoning ("...which is almost the same thing except the opposite.").

Relationship Definition: Self-disparaging remarks ("I can hardly think of what some of my good qualities are."); criticism ("This is one of your lousiest characteristics...."); interruptions to assert one's own position or relationship definition (talking or laughing over someone); direct statements of relationship or definitions of behavior ("You should have been responsible for much more and, you know, we didn't make you."); direct comments of how another behaves or should behave ("You have to be ready to cope.")

Disconfirmation: Coalitions to negate another person (Father speaks but both mother and son ignore him); disqualifications of one's own or another's statements (After agreeing that he took showers when the family was in another state--which a parent has defined as a good quality no longer maintained--the patient continues, "But I was sick down there; I wasn't sick up here."); talking to someone about himself as if he were not present (Mother says approvingly to son/patient, "He signed himself in so he could have the treatment he needs."); slips of the tongue that negate ("I'd get home and find out some thoughtful son had lowered--uh, lightened my work."); definitions of another's intent or inner experiencing ("My very courageous son, who knew he wasn't well..." [committed himself]);

implications of how another feels or should feel, is or should be motivated, etc. ("When someone puts you down, how would you withdraw within yourself?")

Method and Procedure

Subjects were 20 family triads consisting of father, mother, and son or daughter with a current or recent psychiatric hospitalization. Subjects with DSMIII Axis I diagnoses of schizophrenia or schizophreniform disorder comprised one group (eight males and four females); the other group (five males and three females) included all other psychiatric diagnoses, mainly affective disorders (all but one male and one female). All diagnoses met DSMIII criteria and were made independently by two psychiatrists or one psychiatrist and one clinical psychologist; they knew the patients and their hospital charts but were not informed of the research hypotheses. In the three instances of disagreement as to diagnosis, the diagnosis of a third (blind, independent) psychologist or psychiatrist in each case matched one of the other two and was accepted.

Fourteen of the 20 patients were taking medication at the time of participation in the research. To rule out any chance of data-confounding by communication differences due to negative effects of medication or lack of medication response, a medication-response judgment was made for each patient by one of two psychiatrists unaware of research hypotheses, along a

continuum of -100 (designating extreme psychonoxious response to medication) to zero (no psychiatric response) to +100 (optimal response). No negative ratings were assigned. There were no significant differences in medication-response level for patient group or sex.

Family triads (mother, father, and son or daughter who was the identified patient) were asked to participate in a 15-minute video- and audiotaped discussion among themselves. No incentive for participation was offered. Families did not know the topic to be discussed until their actual participation. At that time they were given the task instructions (see below).

Each family triad was brought to a suite of rooms adjacent to the family-therapy ward in the hospital. In one room three chairs were arranged in a crescent shape, facing the door. A microphone hung from the ceiling. Standard, commercially available audiovisual recording unit, television monitor, and videotapes were used to videotape the family interactions. The recording unit and television monitor were in the hall near the doorway; the video camera and tripod were in the doorway, from where the interactions were filmed by an audiovisual technician. Wiemann (1981) has offered evidence that behaviors out of conscious awareness are not significantly affected by videotaping, in terms of knowledge of, anticipation of, or degree of obtrusiveness of the videotaping itself.

The identified patient was requested to sit in the center

chair; the parents chose spontaneously which side next to the son or daughter to take. Families were given the following task instructions, with eye contact with each individual:

"Each of us has many personal qualities. We are like other people in some ways and unique in some ways. Today you are being asked to decide what (possessive form of name of son or daughter) qualities and characteristics are as a person, and how s/he became this way.

"Be sure everyone's feelings and opinions are expressed, then decide as a family what your personal qualities are, (name of son or daughter), and how they developed. I will return to record your consensus."

The researcher read the task instructions to the triad, responded to any questions with repetition of the instructions or the relevant part of them, then left the room. After 15 minutes of interaction, the researcher rejoined the family, interrupting the interaction, and asked for the family consensus (not analyzed for this study).

Communication falling into the categories of egocentric, relationship-defining, or disconfirming communication, and therefore to be identified by the raters, was delineated by the researcher with brackets on typed copies of the interaction transcripts. Raters were instructed to indicate any disagreement with either what was to be rated or what was not to be rated;

this resulted in only a single additional utterance's inclusion in the ratings, and no deletions.

The egocentric (E), relationship-defining (R), and disconfirming (D) communication patterns were rated by three independent judges blind to subject diagnoses and research hypotheses. Two were clinical psychologists (one male and one female); one was a psychiatric nurse (female). All were experienced in working with families.

Raters were trained by use of explanation with examples, tests, and practice on a transcript not used as research data (Bayer, 1982). Criterion accuracy of ninety percent was met or exceeded at all stages of training. Interrater reliability was high: Correlations between the ratings of the three judges and between their ratings and those of the researcher were all significant beyond the .001 level for all three communication patterns.

The analyses performed to test for differences in communication patterns and family relationships were group-by-sex analyses of covariance for each communication pattern, for family systems as well as for individual family members. The effects of patient age and length of hospitalization were statistically removed with analysis of covariance because of a significant group difference (length of hospitalization) and a significant group-by-sex interaction (age).

Results

Table 1 shows significant differences. The first important finding is that in most cases group, sex, family-member, and

Insert Table 1 about here.

family-system differences are consistent whether within the context of only the E, R, and D communication or within the context of the total communication.

The largest group difference for mothers was in R-communication use, and it was the mothers of sons and daughters with diagnoses other than schizophrenia (the O-group) who were responsible for this group difference between mothers: O-group mothers used significantly more R-communication than did mothers of schizophrenics (the S-group). For ERD communication, $F(1, 14) = 7.36, p < .05$; for total communication, $F = 7.53, p < .05$.

Fathers showed greater variability than either mothers or patients, with two group differences, one sex difference, and two group-by-sex interactions. The first group difference was in E: Schizophrenic fathers used significantly more egocentric communication than Other fathers ($F = 10.35, p < .01, ERD$; $F = 10.16, p < .01, total$).

A group-by-sex R interaction revealed that fathers of S-group females used significantly more R-communication than any other fathers, and vastly more than fathers of O-group females.

Both mothers and patients in O-group families used more R-communication than those in S-group families. The fathers are different, however: Fathers of schizophrenics used more R than fathers of offspring with diagnoses other than schizophrenia, and the difference was statistically significant with female offspring. Fathers in families with schizophrenic female offspring defined relationships and dictated behavior directly far more than any other fathers.

Several significant differences in fathers were revealed in D communication. A group difference showed that fathers in Schizophrenic families used significantly more D than O-group fathers ($F = 13.42$, $p < .005$, ERD; $F = 12.15$, $p < .005$, total). A sex difference revealed that fathers of females used significantly more D than fathers of males ($F = 7.50$, $p < .05$, ERD; $F = 9.49$, $p < .01$, total), although most of the significance is due to the inordinately high use of D communication by fathers of S-group females. A group-by-sex interaction revealed that fathers of female schizophrenics used significantly more D than any other fathers, but especially more than any O-group fathers ($F = 5.19$, $p < .05$, ERD; $F = 6.18$, $p < .05$, total).

The only immediately apparent patient difference was a trend for E to be greater for the S-group ($F = 4.15$, $p < .07$, ERD; $F = 4.30$, $p < .06$, total).

It is the family-system differences that were most revealing of the nature of family-communication dysfunction and differences

between groups and by sex of patient. S-group families used significantly more egocentric and disconfirming communication than O-group families; O-group families used significantly more relationship-definition than S-group families. The families were thus distinguishable on E, R, and D as family systems, according to identified-patient diagnoses: E: $F = 7.17, p < .05$, ERD; $F = 6.31, p < .05$, total; R: $F = 29.32, p < .001$, ERD; $F = 26.09, p < .001$, total; D: $F = 7.73, p < .05$, ERD; $F = 7.16, p < .05$, total.

Besides the group difference in disconfirming communication, a sex difference was significant for family systems. Families with female patients disconfirmed significantly more than families with males: $F = 5.73, p < .05$, ERD; $F = 7.19, p < .05$, total.

Although in the fathers' communication the amount of R was highest for Schizophrenic females and lowest for Other females, for both patients and mothers, R use was highest for Other males and lowest for Schizophrenic males. This combination produced a significant group-by-sex R interaction in total communication for family systems: $F = 7.03, p < .05$.

Discussion

The contribution of this research is believed to be threefold: (1) It was designed and executed within a systems epistemology, and the results support a systems epistemology. It

is very useful to have hard data revealing family-system differences as well as individual differences and that the combination of patterns distinguishes schizophrenic families from other families even more clearly than a single pattern does.

(2) The research offers empirical support to current theoretical and research models (Lidz, Wynne and Singer, Laing, Bateson, Blakar, and their colleagues), with the caution that each may be emphasizing or focusing upon only a part of the total picture.

(3) The research demonstrates clear family differences consistent with psychiatric diagnosis, offering utility in the clarification of diagnostic and treatment issues.

Two questions were of interest post-hoc. One involved dominance vs. submissiveness in the parental dyad. None of the 20 families was characterized by spousal equality; in each, one spouse was dominant even though spousal relationships were sometimes complementary and sometimes symmetrical (Watzlawick et al., 1967). A post-hoc analysis of covariance was performed to investigate whether parental communication differences would intensify or attenuate if the data were analyzed by dominance/submissiveness regardless of sex of parent, rather than by parental role in family (i.e., father or mother).

If analyzing the data by dominance/submissiveness increased group or sex differences, the implication would be that it was the communication of whoever was dominant or submissive that

accounted for parental communication differences; if the differences were reduced, the original finding of family-member distinctions would be reinforced. In fact, the latter occurred.

Only trends appeared in the analysis according to dominance/submissiveness, whereas clear parental-role (mother or father) differences exist between groups and sexes. It is not the dominance/submissiveness variable in parent communication that increases the parental portion of family communication dysfunction, but the specific contributions as mothers and fathers that create the communication differences.

The other question involved dominance vs. submissiveness in patients, in relation to parents. An examination of parental R and D communication revealed that parents rarely directed R or D communication toward themselves or each other, directing 90 to 98% of their R communication and 85 to 100% of their D communication to their sons or daughters (both groups and sexes). Patients, however, varied according to group: In the S-group families, patient R communication was not only less frequent than O-group R, but also S-group patients expressed submissiveness 32% of the time. In the O-group families, patients were very assertive: 96% of their R communication was assertive about themselves or dominant toward their parents. Both male and female S-group patients used submissive R about a third of the time that they used R, whereas both male and female O-group patients used assertive or dominant R almost completely.

When S-group patients used D, 48% of the time it was self-disconfirming; however, O-group patients were as able to disconfirm parents nearly as often as parents disconfirmed them (84% other-disconfirming and only 16% self-disconfirming). Thus patient group differences exist also in target of the D-communication.

Summary

Many family-interaction researchers have sought to define what kinds of communication distinguish functional from dysfunctional families, and between diagnostic categories, when one family member is psychiatrically hospitalized. The research of Wynne and Singer and their colleagues, for example, points to a nebulous, confusing, idiosyncratic communication in schizophrenic families, communication which suggests egocentricity in the speaker. Work by Laing and by Bateson and other communication theorists indicates that schizophrenic families negate certain family members, preventing autonomy and individuation. clinical experience and research into communication reflecting power and control issues emphasize nonnegotiable definitions of relationship limits and expectations among family members in dysfunctional families; however, these relationship definitions are covert in schizophrenic families and overt in families with other psychiatric diagnoses.

The communication patterns of the 20 families examined in

this research were consistently more egocentric and disconfirming in families where the identified patient was diagnosed as schizophrenic, and more openly relationship-defining in families with a different patient diagnosis. This research supports the schizophrenic-family interaction theory and research of Lidz and of Wynne and Singer (primarily reporting E types of communication); of Laing and of Bateson and the Mental Research Institute (primarily reporting D types of communication); and of Blakar and his colleagues (reporting both E and D communication).

In addition, the research, conducted with careful methodological controls, supports a systems epistemology, in that system differences distinguish groups even more dramatically than differences between individual family members.

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Table 1

Significant Communication-Pattern Differences for Family Members and Family Systems

	<u>F-Values</u>						
<u>Family Member</u>	<u>ERDA Communication</u>			<u>Total Communication</u>			<u>Nature of Difference</u>
	<u>E</u>	<u>R</u>	<u>D</u>	<u>E</u>	<u>R</u>	<u>D</u>	
Mothers		7.36*			7.53*		<u>Group</u> difference: O-group mothers use significantly more R than S-group mothers.
			5.11*			3.63*	<u>Group-by-sex</u> interaction: Mothers of O-group males use significantly less D than any other mothers.
Fathers	10.35**			10.16**			<u>Group</u> difference: S-group fathers use significantly more E than O-group fathers.
		3.78*			5.42*		<u>Group-by-sex</u> interaction: Fathers of S-group females use far more R than any other fathers, especially more than fathers of O-group females.

* p < .09
 * p < .05
 ** p < .01
 *** p < .005
 **** p < .001

Table 1 Continued

	<u>F-Values</u>						
<u>Family Member</u>	<u>ERDA Communication</u>			<u>Total Communication</u>			
	<u>E</u>	<u>R</u>	<u>D</u>	<u>E</u>	<u>R</u>	<u>D</u>	<u>Nature of Difference</u>
Fathers (continued)			13.42***			12.15***	<u>Group</u> difference: S-group fathers use significantly more D than O-group fathers.
			7.50*			9.49**	<u>Sex</u> difference: Fathers of females use significantly more D than fathers of males.
			5.19*			6.18*	<u>Group-by-sex</u> interaction: Fathers of S-group females use significantly more D than fathers of S-group males, but vastly more than fathers of O-group males or females.
Patients	4.15*			4.30*			<u>Group</u> difference: S-group patients use more E than O-group patients.

* p < .09
 * p < .05
 ** p < .01
 *** p < .005
 **** p < .001

Table 1 Continued

<u>F-Values</u>							
<u>Family Member</u>	<u>ERDA Communication</u>			<u>Total Communication</u>			<u>Nature of Difference</u>
	<u>E</u>	<u>R</u>	<u>D</u>	<u>E</u>	<u>R</u>	<u>D</u>	
Systems	7.17*			6.31*			<u>Group</u> difference: S-group families use significantly more E than O-group families.
		29.32****			26.09****		<u>Group</u> difference: O-group families use vastly more R than S-group families.
					7.03*		<u>Group-by-sex</u> interaction: S-group families with male patients use significantly less R than any other families.
			7.73*			7.16*	<u>Group</u> difference: S-group families use significantly more D than O-group families.
			5.73*			7.19*	<u>Sex</u> difference: Families of females use significantly more D than families of males.

* p < .09
 * p < .05
 ** p < .01
 *** p < .005
 **** p < .001

Table 1 Continued

<u>F-Values</u>							
<u>Family Member</u>	<u>ERDA Communication</u>			<u>Total Communication</u>			<u>Nature of Difference</u>
	<u>E</u>	<u>R</u>	<u>D</u>	<u>E</u>	<u>R</u>	<u>D</u>	
Systems (continued)			5.73*			7.19*	<u>Sex</u> difference: Families of females use significantly more D than families of males.

* p < .09
 * p < .05
 ** p < .01
 *** p < .005
 **** p < .001